

**TO: ALL PROVIDERS**

**FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A**

**DATE: FEBRUARY 7, 2005**

**SUBJECT: AVOIDING DENIALS IN MEDICAL REVIEW**

The main focus of the Local Provider Education and Training (LPET) initiative at CareFirst of MD, Inc. is to help providers to avoid claim denials during the medical review process. The medical review process involves four distinct components – Data Analysis, Medical Review, LPET, and Appeals. Each of these components contributes to provider education to reduce the denial rate. In an attempt to avoid denials (and thus appeals), this article offers suggestions for developing strategies with which to build more efficient and accurate billing practices.

Data analysis begins the Medical Review process with an edit which addresses a particular area of concern. The focus of the edit may be stimulated by the increased utilization of a particular service; trend reports; denial information from the CERT contractor; or from other data analysis findings which prompt medical review. Each edit is assigned a number, and claims in the system containing that edit are identified. The provider responsible for those claims then receives an Additional Development Request (ADR). This is a formal request for documentation relevant to the edit which contains a detailed list of medical record components that should be submitted to Medical Review.

There are two Medical Review concerns that have already been identified as standing out:

- 56900 denials--Records not received within allotted 45 days. The date contained on the top left hand corner of the ADR begins the clock for the allowed forty-five days to submit these records to CareFirst of MD, Inc. Facilities should standardize their procedures beginning with the receipt of their mail to insure proper routing for ADRs, as many providers deny receiving the original ADR in the appropriate department.
- 54018 denials--Services not documented. Submitting all requested documentation is the key to avoiding 54018 denials. Title XVIII of the Social Security Act, section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Please note that facilities should submit all of the information in the ADR. The requested information is medically reviewed to insure that the claim is paid correctly in compliance with Medicare guidelines. If any information necessary to review the claim is not submitted, the claim will be partially or fully denied as indicated by the review.

Facilities should be familiar with all information resources available to them such as LCDs, NCDs, CMS Manuals, transmittals, change requests, etc. The national CMS and local contractor websites should be reviewed often and all information forwarded to applicable departmental personnel. Another focus in this area would be to implement a final audit process prior to records submission. An effective process might simply be to have qualified personnel review records to be sent as a final step prior to submitting the records. Not only could proper documentation be reviewed for accuracy, but it would also insure that correct dates of service, complete diagnoses lists, and other requested items contained on the ADR, are accurately reflected. This would help eliminate unnecessary denials that count toward your overall claims payment error rate and may result in a more intensive level of medical review. Providers are encouraged to keep a copy of the records they submit to Medicare in order to quickly see what was actually sent.

Facilities should also consider increased monitoring of submitted claims. Monitoring of the Medical Review suspense location in the FISS system (represented by claims in SB6001) should identify claims suspended for requested records. More stringent monitoring will alert providers to records submitted but not yet received by CareFirst of MD, Inc. There are other things a provider can do to better insure that records are received and processed (See related Medical Review article on our web site at [www.marylandmedicare.com](http://www.marylandmedicare.com) dated September 20, 2004 titled Procedures for Additional Development Requests (ADRs) Related to Claims in Medical Review). Addressing some of these tips for correct ADR submission and tighter controls in claim tracking should assist in decreasing the resources utilized for appealing these claims, and better still, capture lost reimbursement.

Once medical records are received, the Medical Review nurses review them for medical necessity and the correct application of CPT/HCPCS codes. Upon completion of the nurse review, the results are analyzed. This analysis helps track correct and aberrant billing practices, thus identifying educational needs to be addressed by LPET. The parameters considered for intervention by LPET include the number of claims reviewed per provider, total denial percentage per provider, and patterns of specific providers.

Educational contacts are made by LPET to compliance officers, usually either by phone or e-mail. It is crucial that LPET have the correct contact information on file to facilitate education being routed properly for prompt attention to issues as they arise. All facilities were sent a letter of request for this contact information last year. The responses to this request are kept on file, and updated as needed.

When a claim that was denied by Medical Review is appealed, our appeals staff will conduct a complete review of all services denied to determine whether the denied services qualify for Medicare payment. As a result of the appeal review process, the denial may be reversed and the services paid, the services may

remain denied as determined by the initial medical review, or the services may be denied for a different reason.

Often the information submitted with the appeal request (e.g., physician progress notes, physician orders, and pathology reports) is incomplete. It is important to submit all information from the medical record to support the appeal request since CareFirst will not ask for additional information. In addition, when requesting an appeal, please be sure to submit the medical documentation you previously submitted with your ADR. Submitting all information from the medical record allows the Appeals staff to conduct a thorough review of the services originally denied. It also ensures that the appeal file contains all information needed to complete the review.

The intent of this memorandum is to emphasize the importance of tighter controls as a mechanism for reducing denials in Medical Review. This entire medical review process, one that is intended to assist providers in accurate billing, coding, and documentation practices, can be easily complied with once appropriate processes are implemented. It is vital that providers appreciate the significance of these ADR requests and medical review processes involved.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.